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ABSTRACT

Members of the academic and intellectual community are often faced with the dilemma of finding themselves inured to the lives of the individuals for whom they profess advocacy. Drawing on the real-life experiences of children and families in need, this paper places social-service agencies, professionals, and services within their historical and social contexts. The paper argues that the professionalization of the human service disciplines and the adherence to positivist research methodology has resulted in the social construction of clients and the pervasive use of the medical model. Further, the union of human-service professionals with bureaucratic structures is anathema to client-centered, collaborative practice. The human-service system must be transformed through a redefinition of traditional conceptions of child/family/client-centered, collaborative practice. Possibilities for reframing human services include: (1) community-based programming, which prevents the removal of children from homes and/or communities; (2) human-service professionals who function as enablers and advocates; (3) parallel agencies that coexist at a single, nonhierarchical site; (4) the empowerment of clients to solve their own problems; and (5) value given to the ethic of caring. Contains 40 references. (LMI)

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LOST CHILDREN, LOST VOICES: A CRITICAL EXAMINATION OF COMMUNITY INTERAGENCY SERVICES

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LOST CHILDREN, LOST VOICES:
A CRITICAL EXAMINATION OF COMMUNITY INTERAGENCY SERVICES

Introduction: Jeremy

Jeremy looks at me with sad brown eyes peering from beneath the brim of a baseball cap that casts a shadow across his face. He is wearing an oversized t-shirt emblazoned with basketball logos. Baggy orange and black striped shorts hang below his knees, swallowing his slight frame. He is 13 years old and 300 miles from his home. He been living in a residential treatment program for the past two months, but his future is uncertain. Why is Jeremy so far away from his home? When he was three years old, Jeremy's family was accused of abuse and he was placed into the custody of the department of social services in the rural, sparsely populated county in the southern state in which he resided. Jeremy was subsequently labeled behaviorally-emotionally handicapped and assigned to a special, court-monitored program for violent and assaultive children.

Because the services Jeremy's treatment team decided he needed were not available in his poor, rural, isolated community, and they also decided that removing him from his home was in his best interest, the local mental health center entered into a contract with a private, non-profit company to provide an alternative family placement for him. A therapeutic family was recruited, but was located in the central part of the state, in a more urban area with more opportunities. So Jeremy was placed with the family, arrangements were made with the mental health center in his new county for services, and Jeremy was enrolled in the county's school system. Collaboration between agencies and counties seemingly had facilitated a smooth transition for Jeremy to begin a new life.

However, several months into the placement, Jeremy began to experience trouble at school, trouble which soon carried over into his therapeutic home. The school expelled Jeremy at the beginning of March. Shortly thereafter, his therapeutic

family felt they could no longer maintain him in their home and requested that he be moved. Jeremy was then placed in another residence operated by the same private company, but which was located in a neighboring county. The school system in Jeremy's new county of residence would not allow him to attend school until the department of social services in his home county enrolled him. Moreover, since Jeremy is no longer residing in the county where he was originally placed, the mental health center in that county believed it was no longer responsible for him.

Jeremy, at age 13, is a lost child living 300 miles from home in a residence operated by a private company with staff paid to live with him; a lost boy who is not only lost in the system, but whose life is in upheaval while professionals ponder about his future. Jeremy is a lost boy whose voice has been disregarded and marginalized by the system that was supposed to improve his life and provide him with the stability determined to be lacking in his natural home.

Jeremy's story is all too familiar to administrators, teachers, social workers, therapists, and others who have attempted to navigate the human service delivery system on behalf of children. Schools and other human service organizations that comprise the service delivery system typically assert a mission and philosophical stance reflective of client-centered, collaborative practice. The following quote is typical of how such organizations are defined: "A client-centered organization has clearly defined its mission, purpose, and performance and commits all its knowledge, resources and talents getting it done" (Gowdy, Rapp & Poertner, 1993, p. 13).

Yet, as Jeremy's story illustrates, schools and other community programs are often unable to translate their missions into practice. As an ever larger number of children are experiencing abuse, neglect, and the effects of poverty and dysfunctional families, they have needs far beyond the scope of what schools or any single agency can provide, and it is therefore essential to critically examine the

practices of the entire community human service system that seem inconsistent with their stated purposes.

Themes: Praxis, Human Service Professionals and Bureaucracies

As members of the academic and intellectual community, we are often faced with the dilemma of finding ourselves inured to the lives of the individuals for whom we profess to advocate. By engaging in abstract theorizing often far removed from the real lives of people with needs, it is easy to lose sight of the purposes for theorizing in the first place. With that in mind, the themes of this paper are multiple. First, it draws upon the real life experiences of children and families in need and places them at the forefront of the discussion. This is consistent with what Lather (1991) and other feminist writers (e.g. Fine & Gordon, 1992; Weiner, 1994) have described as praxis. Lather noted that "the requirements for praxis are theory both relevant to the world and nurtured by actions in it, and an action component in its own theorizing process that grows out of practical political grounding" (pp. 11-12).

A second theme of this paper is to place the service agencies, the professionals who work in them, and the practices that gave rise to such constructs as clients, institutions, and human services, within their historical and social contexts. Doing so will demonstrate the enduring nature of values nested in reified assumptions about clients, human services, and professional practice that are antithetical to espoused professional and agency values to engage in child /family /client-centered, collaborative practice. Using literature from the fields of special education, social work and psychology, a third theme of this paper is to propose that professionalization of the human service disciplines and adherence to positivist research methodology has resulted in the social construction of clients and the pervasive use of the medical model, which is central to professional practice.

Because it is difficult to separate human service professionals from the schools and agencies employing them, a fourth theme is to suggest that the union of human service professionals with bureaucratic organizational structures is anathema to client-centered, collaborative practice. Although the majority of the literature (see, for example, Majone, 1984; Raelin, 1986; Blau & Meyer, 1987) concerning human service professionals and bureaucratic organizations considers this relationship problematic, bureaucracy is still perceived as an inevitable, immutable form to which professionals must learn to adapt. Other writers (such as Steinman & Traunstein, 1976; Street, 1978; Skrtic, 1991) have argued that the convergence of professionalization with bureaucratization has contributed to the continued dependence and marginality of clients, as well as to the perpetuation of poverty and injustice.

Finally, the themes of child/family/client-centeredness and collaboration are interwoven throughout each section as I argue that current professional and agency practices do not support these goals. Certainly not a new concept, interagency collaboration has recently regained momentum as the solution for improving the efficiency and effectiveness of a human service delivery system that seems fragmented and lacking in coherence. Efforts to facilitate collaboration of community services have thus far proven frustrating and less than satisfactory. Additionally, guidelines for successful services integration tend to offer prescriptive and technical solutions to problems that are political, social and cultural in nature. As a result, the human service system has been unable to move beyond rational, functional-structuralist approaches for achieving collaboration (see, for example, Beatrice, 1990; Wimpfheimer, Bloom & Kramer, 1990; Guthrie & Guthrie, 1991; Melaville & Blank, 1991).

Back to the Future?

Throughout recorded history human beings have experienced a range of social concerns: poverty, dependent and neglected children, individuals with physical and mental disabilities. Public response to these concerns has varied greatly over time. Colonial America relied on the church, the community and the family to respond to these kinds of social problems, with the notion of helping others embedded in a religious context. At the beginning of the 19th century four major developments occurred that profoundly reshaped the economic and social order of North American society: (1) industrialization and urbanization, (2) the state assuming direct responsibility for some aspects of social welfare, (3) institutionalization was created as a solution to social problems, and (4) the family was redefined (Petr & Spano, 1990; Katz, 1992).

Orphan asylums, houses of refuge, almshouses, and institutions for the mentally ill and mentally disabled proliferated. Although these institutions varied with regard to the program offered and specific population served, they shared a common ideological perspective congruent with the social and economic conditions of the day. Society was viewed as on the brink of collapse due to crumbling social structures, particularly the family, and institutions could provide social stability through rehabilitation. This perspective of rehabilitation rested on the dual premises of discipline and reform, both of which were believed to be needed by all children.

Additionally, inherent in this approach to rehabilitation was the view that these children could be best served away from the negative influence of their environments, especially their families. Thus, the institutional approach to solving the problems with America's youth resulted in the birth of large institutions designed to discipline, control, and reform wayward children in isolation from their families and their environments. Because their children were seen as flawed and

deficient, parents were considered unworthy and morally unfit to rear them. Thus, reformers justified the state's authority to remove children from their homes and to intervene in *loco parentis*, in the place of the parents. Reformers assumed that they alone knew what was in the child's best interest, and this notion formed the basis of child-centered practice (Petr & Spano, 1990).

Along with the proliferation of institutionalization, religiously motivated philanthropic societies and charitable organizations constituted the first voluntary efforts to meet the needs of immigrants and other marginal populations during the early part of the 20th century typically referred to as the Progressive Era. These early efforts to minister to the needy included exhortations to reform their personal habits and to obtain employment. Progressive philanthropists carried these early charity efforts forward by embracing the newly emerging knowledge of the social sciences to establish a design for therapeutic intervention that would provide the template for modern human services. The therapeutic model conceived by Progressive reformers consisted of contact with the marginal family, diagnosis of the problem, implementation of normalizing measures, ongoing contact with agencies, and continued oversight. Special emphasis was placed on remediating immigrant and working-class families who were viewed as deficient, maladjusted, and incompetent (Polsky, 1991). In their enthusiasm to promote white, middle-class values, no one questioned that working-class and immigrant families were not marginal until defined as such by reformers.

Progressive reformers used empirical evidence and social science explanations derived from objective scientific methods to justify their moral assumptions about the families and children they considered deviant. Social science was also seen as the key to the success of therapeutic intervention and provided the foundation for many new disciplines: sociology, social work, psychology, behavioral science, and

counseling, among others. Since the family lacked this scientific knowledge, they were dependent upon the caseworker to apply his/her expertise in their home.

Expertise thus became the definitive power resource as the caseworker had the power to raise the quality of family relations or to enhance an individual's capacity to function in modern society. The allure of science to Progressive philanthropists seemed to reside more in its ideological appeal than its instrumental value, as the therapeutic enterprise was celebrated as a victory over previous philanthropic ignorance. Therapeutic intervention was a mission worthy of pursuit by decent, educated, middle-class activists, as they had the power to ease misery and distress, to heal wounded people, and make fractured families whole again (Petr & Spano, 1990; Polsky, 1991).

"Enlightened middle-class behavior set the standard for therapeutic adjustment" (Polsky, 1991, p. 51). Therapeutic caseworkers therefore selectively eliminated the undesirable behavioral patterns of immigrant and working-class families, including their cultural heritage, then taught replacement skills designed to help them cope with their environments. By participating in these social programs, immigrant and working-class families were to be restructured and expected to emerge with significantly altered lifestyles.

It is not surprising that such reform efforts have been criticized for their attempts to remake working-class and immigrant families in the image of middle-class white America and for promoting self-serving moral authority moreso than any genuine altruistic motives (Jimenez, 1990; Petr & Spano, 1990; Polsky, 1991). Yet, in spite of these criticisms, it is apparent from this cursory review that the basic values and assumptions concerning human service programs adopted during the Progressive era, both institutional and community-based, have continued to prevail as accepted practices in our modern human service system.

For example, researchers Steinman and Traunstein (1976) asserted that human service professionals have historically believed their clients lacked the competence to understand and solve their own problems. Ferguson (1984) maintained that service bureaucracies gave rise to knowledge about clients through their power over them. Giroux (1992) also asserted that even those who consider themselves liberals espouse a philosophy that marginal and oppressed groups need to be "remade in the image of dominant white culture in order to be integrated into the heavenly city of Enlightenment rationality" (p. 116).

The hegemony of socially legitimated professional expertise and knowledge combined with the legal authority delegated to agencies allowing them to become involved in the intimate details of the lives of individuals and families under the guise of "helping" has historically functioned as a powerful mechanism for oppressing and controlling marginal individuals and groups.

Human Service Professions: Amy

Amy, a blue-eyed waif with long brown hair streaming down her back, just celebrated her eighth birthday. She has much to celebrate this year -- she is soon to leave the institution for children with developmental disabilities to live with a new family. Amy is the product of an abusive and neglectful family and has been in the custody of the department of social services since she was four years old. Confused and conflicted, Amy responded to her intolerable situation with anger manifested as aggression, violence, destruction, and emotional lability. She experienced nightmares and frequently woke up during the night screaming and crying. The adults who were supposed to care for her had failed to fulfill their obligations and she bears the emotional scars of their neglect.

Fortunately, Amy was soon placed with a foster family who provided her with the stability and nurturing lacking in her home. However, since she was doing

so well, her maternal grandparents then requested that she come live with them. Although they resided in a state on the west coast, the professionals responsible for Amy's life believed that living with her natural family was in her best interest, so they made arrangements to send Amy to live with her grandparents. Knowing that abuse, like poverty, is a cycle, it should have come as no surprise that Amy's grandparents resorted to physical abuse when she experienced difficulty with controlling her emotions. As a result of her emotional problems, Amy did poorly in school, was referred for special education, and when tested was diagnosed as mildly mentally disabled and behaviorally-emotionally handicapped. She was then placed into a segregated special education class.

Within a year, Amy was returned to her home county and placed with another foster family, however this family already was caring for ten other children, both their own and foster children, and was unable to provide for Amy's expanding list of special needs. A new family has been recruited and they are anxious for Amy to come live with them. In the meantime, Amy was placed in the institution for further evaluation and diagnosis. She recently visited with her new mom and dad for an overnight, but was not allowed to stay more than one night because the institution would lose money with her bed vacant. Amy and her new mom said tearful good-byes when Amy was returned to the institution following the visit. Seeing her tears, the staff member who met Amy at the door indicated that she had better be on her best behavior if she wanted to live with her new family. Amy essentially has to prove herself worthy of placement with her new family. Little wonder that she is distrustful and suspicious of any adult she thinks is "clinical" or a "professional".

Human Service Professionals: Service or Self-Interest?

Prior to the end of the 18th century, the professions were widely recognized in Western Europe and North America as a unique occupational form. Exemplars of this group included physicians, clergymen, attorneys, and university professors. The professions have typically been associated with an elitism based in part on the tendency to draw their membership from privileged groups and in part from conceptions of professional authority. The professions "profess to know better than their clients what ails them or their affairs" (Hughes, 1965, quoted in Steinman & Traunstein, 1976).

Professionalization has been defined as the process by which service occupations attempt to establish a publicly accepted monopoly of expertise for the purpose of attaining power and prestige (Street, 1978). Considering the trend of such service-oriented occupations as teaching, social work, counseling, and psychology to achieve some arbitrarily imposed standard of professionalization, this assertion has significant implications for practice.

No one would argue that expansion of theory and knowledge through systematic research is essential to any field, but it begs the question of whether the primary motivation for doing so is to advance the status of the profession or to develop practices that enhance the quality of life of individuals with special needs. These ends are not necessarily mutually exclusive, but a delicate balance exists between service and self-interest. Nevertheless, the means to achieve these ends can be problematic, particularly since the majority of extant theory and knowledge base influencing professional practice is not only based on middle class values, but reflects white, able-bodied, male, and heterosexual standards for what constitutes normal and acceptable behavior. Additionally, as Ferguson (1984) pointed out, as human service professionals have attempted to raise their own status through professionalization, they have become more preoccupied with attaining the language,

code of behavior, and style of analysis associated with the profession than delivering services to clients.

Moreover, social science inquiry has been dominated by positivist, functionalist methodologies that assume objectivity and scientific neutrality, and that show a preference for data over theory (Skrtic, 1991). This obsession with methodology has created professional disciplines whose primary goals are the application of techniques rather than investigating and addressing issues of genuine importance to the experiences and situations of people. The positivist approach to inquiry is common to most human service disciplines and extends beyond theory to professional practice (Bohan, 1992). This is evident in the medical model approach to service delivery in which clinical decisions are justified under the guise of objectivity and scientific neutrality.

Interestingly, the various service professions are perceived as maintaining conflicting ideologies that undermine and even discredit the strategies of other professions (Street, 1978). Often cited as a reason for the failure of collaborative efforts, animosity among the service professions is hardly the foundation upon which to build client-centered collaboration. However, this perspective assumes each profession maintains a separate, monolithic ideological stance. Since the majority of the human service professions find their roots in the social sciences and the legacy of logical positivism, I would argue instead that human service disciplines have similar ideologies. Although they may differ with regard to choice of method, technique, or treatment modality, all predominantly assume a categorical approach that results in a decontextualized view of the individual in need of services.

Regardless of professional orientation, most human service professionals generally espouse philosophies consistent with humanitarian and altruistic missions. However, a more critical analysis reveals unequal power relationships and perpetuation of client status through exercise of professional authority. As

previously mentioned, the concept of "client-centered practice" has historically meant a paternalistic and hegemonic exercise of professional expertise, and assumes the professional is more knowledgeable about what treatment or course of action is in the best interest of the clients. On the other hand, the human service professions need clients in order to survive and thus compete with one another for ownership and the power to construct clients' realities through application of specialized clinical techniques and professional expertise. Therefore the client, rather than ideology, is contested terrain as professionals struggle with one another to determine what is "in the best interest of the client," which generally results in fragmentation of services and duplication of efforts.

The Medical Metaphor

The therapeutic model of intervention conceived by the Progressive reformers is an unsuitable application of a medical model to individuals with disabilities and other problems, yet is consistently used across human service disciplines, including special education. This approach to provision of services is central to the curricula of university programs preparing special education teachers and other human service professionals, is widely accepted practice, and has not been seriously challenged. By adopting the same approach to practice as the medical profession, legitimacy is perhaps afforded to disciplines striving to achieve recognition as professions.

The language of human service and special education discourse adopts a pathological, or deficiency attitude towards persons with any kind of problem, whether financial, physical, or mental. (Weick, 1983; Murphy, 1989; Skrtic, 1991; Pardeck & Murphy, 1993). Within the medical model, individuals are first assessed and evaluated, and their deficiencies are diagnosed and given labels and/or placed into categories such as mental illness, developmental disability, homeless, etc. The professional then prescribes treatment or recommends programs ranging from

counseling, therapy, financial and housing assistance to placement into special education classes or residential treatment programs. Professionals also maintain copious written documentation about their clients, usually in the form of a medical record. Finally, the professional provides ongoing monitoring of each person's progress.

The medical model emphasis on the individual who presents with a set of symptoms/problems is ahistorical, decontextualized, and based on the assumptions of technical, value-neutral objectivity. By focusing primarily on the individual, the medical model also disregards the social and economic circumstances impacting upon the lives of people that resulted in the need for services in the first place. Unfortunately, funding of programs and services is closely allied with this categorical approach to service delivery. Medicaid and private insurance companies will reimburse for services only if individuals have specific diagnoses and/or meet pre-determined criteria.

The Social Construction of Clients: Othering

In order to receive needed services, people are required to be transformed from socially valued individuals and redefined as client, clinical subject, or case. Children and adults with disabilities or other problems must prove they are worthy of attaining this status before they are eligible to receive needed services or benefits (Biklen, 1988). Once this dubious status has been attained, clients are remade as Other and therefore no longer able to speak for themselves. They are unable to articulate their own concerns, as client perspectives are considered invalid, irrational, incompetent, and as such, are subsequently disregarded. It is not uncommon for human service professionals to use a client's diagnosis to justify ignoring and invalidating his/her concerns - "s/he's schizophrenic and delusional, therefore you can not believe everything s/he says." In the process of being created as Other, people with problems are often personified by the category into which their problem

has been placed; they become the paranoid schizophrenic, the homeless, the substance abuser or the pregnant teen. Clients are no longer multi-faceted people who happen to have a disability or other problem for which they need services, they are their problem.

A central dynamic to construction of clients is accession to professional expertise, termed by Weick (1983) the "giving over" process (p.467). This process involves not merely giving information about oneself to a professional, but giving over the power to create meaning out of this information. In other words, a client is inscribed by a professional who infuses the client's personal information, knowledge and experience with meaning. The expectation that clients should give to someone else the power to define their personal realities is problematic, particularly since a client's experience can have multiple meanings, and some interpretations of experience are privileged more than others because they conform to the explanatory theories subscribed to by the dominant culture (Hare-Mustin & Marecek, 1988).

However, clients are also not merely passive recipients of role assignment as they actively participate in the construction of their client identities. Most clients of service agencies understand exactly what they must sacrifice in order to receive needed assistance. Some collude, cooperate and do whatever it takes to ensure their needs are met. Others more actively resist, sometimes by overtly refusing to cooperate and sometimes through more subtle means such as adopting a posture of dependency and helplessness or taking advantage of loopholes in the system.

This analysis is not to impugn clinical judgment and professional expertise, as they do play important roles in the lives of people with needs. However it is essential to keep in mind that clinical judgment is a political act with real consequences for the children, adults and families who seek assistance. As researchers and practitioners, we must recognize the tremendous power we have been granted to exercise over children and their families. As such, we must begin to

challenge what it means to be human service professionals by engaging in critical, reflective practice. We must examine our participation in the construction of Others. We must also actively involve ourselves in social struggles with those who have been exploited and subjugated and begin to break down categories and boundaries, by engaging in what Fine (1994) has termed "working the hyphen" (p. 72) between Self and Other.

Human Service Bureaucracies: Michael

With a backpack slung over his shoulder and sporting tortoise shell framed glasses, 18 year old Michael appears to be the model high school student. However, Michael's appearance belies the fact that he has been in and out of service agency programs for the past ten years. He came to the attention of social service personnel at the age of eight because he was beating his younger siblings and his mother in turn beat him in her efforts to control his behavior. Michael's mother was uncooperative and resentful of social service intervention into her private life and her relationship with agency personnel has been tempestuous and stormy.

Michael continued to experience problems with aggressive and destructive behavior, was subsequently diagnosed as behaviorally-emotionally handicapped and placed into special education classes. As the years went by, Michael's anger escalated into sexual assaults against several of his female classmates. He then became involved with the juvenile court system, was placed into a special court-monitored program for violent and assaultive youth, and was admitted to a residential treatment program for youthful sex offenders. Michael's relationship with his mother continued to deteriorate and it was determined by his treatment team that since she was unable to effectively manage his inappropriate behaviors, it was in Michael's best interest to be placed into the custody of the department of social services. When he was released from the treatment program for sex offenders,

Michael did not return to his mother's home, but was placed into a specialized community-based residential treatment program where he was to receive treatment until he "aged out" of children's services.

The day before Michael's residential treatment program was to end, which occured three weeks after he reached his eighteenth birthday, it became apparent that no one from social services, mental health, the school system, or juvenile court had made any plans for Michael once he left the program. No one had assisted him with transitioning from children's services to adult services, with making housing arrangements or with applying for special assistance or other funding. Once he reached the age of majority, organizations that had been closely involved with Michael's life for the past ten years had suddenly managed to allow him to slip through the cracks.

Human Service Bureaucracies: "Instruments of Domination"?[1]

The bureaucratic organizational form as conceived by German sociologist Max Weber was envisioned as the technically most efficient possible. Weber's conception of bureaucracy included rules and regulations, a division of labor, a clearly defined hierarchy of offices, technical expertise, standardization of work processes, and a career orientation (Clark, 1986; Pugh & Hickson, 1989). This organizational form was adopted by schools and other public service agencies during the early part of the 20th century, when America was embracing the notion that science and scientific progress held the answer to all social problems. Bureaucratic organizations, like science, were assumed to be apolitical, objective and value-neutral. Bureaucratic administrators were models of impersonal rationality and made decisions based solely on objective facts.

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[1]Morgan, G. (1986). *Images of Organization*. Newbury Park, CA: Sage Publications, p. 273.

Bureaucracy has often been blamed for the failure of schools and other human service organizations to adequately meet the needs of children and their families. Yet, the assumptions of the bureaucratic paradigm are so embedded within American social institutions that, until recently, they have never been seriously questioned. Astuto and Clark (1992) contended that our traditional ways of thinking about schools has us trapped in a set of nested assumptions that constrain us from considering options for authentic reform. This same argument is applicable to other human service organizations. No one would disagree that current structures are not working for practitioners, students, their families, or anyone needing services, and the literature is replete with criticism of the bureaucratic form as inappropriate for schools and human service agencies (in addition to Astuto & Clark, 1992, see Ferguson, 1984; Clark, 1986; Morgan, 1986; Murphy, 1989; Rimer, 1989; Gardner, 1992).

Writing from a radical feminist perspective, Ferguson (1984) asserted that in American society, bureaucracy is located within a context in which social relations between classes, races, and gender are asymmetrical. Hence, a primary function of bureaucratic organizations is to maintain social control and order, for without bureaucratic control, it is believed that society would be reduced to chaos and anarchy. She also claimed that the real purposes of such organizations are those that "keep the machinery of the institution running" (p. 9), whereby the means become the ends. Furthermore, the role of human service organizations in society is to "process, regulate, license, certify, hide, or otherwise control individuals (p. 123). Perrow (1978) also maintained that the actual goals of human service organizations are to regulate the behavior of deviants, to furnish employment to an expanding workforce, and to provide resources to other organizations.

Murphy (1989) critiqued service bureaucracies for restricting what counts as knowledge to empirical information deemed to have significant utility by policy

makers, administrators and professionals. He argued that service bureaucracies are inefficient because irrelevant knowledge is used to justify decisions, the implementation of decisions is socially insensitive, and because only those with professional expertise are permitted to establish priorities and formulate policies.

In her study of social worker "activism," or commitment to advocate for clients, Reeser (1992) found that those workers who identified primarily with the values of the bureaucratic organization were more committed to implementing agency policy and standards and tended to adopt a more conservative stance toward advocacy. In other words, these social workers were not willing to advocate for clients if it meant jeopardizing their careers or otherwise compromised their relationship with the employing agency. Frith (1981) put forth a similar argument in his discussion of advocacy dilemmas faced by special education teachers who were asked to advocate for students when doing so conflicted with the school system's directives.

One can see that the combination of professional expertise with bureaucratic notions of social control can be a powerful and oppressive force, especially since clients are usually found on the bottom rung of a bureaucratic hierarchy that places professional status above that of clients. "A bureaucratic rendition of society conceals its human core. Life...is reified under a bureaucracy..." (Murphy, 1989, p. 82). Bureaucracies therefore must be dismantled and replaced by organizations grounded in praxis and social responsibility.

Interagency Collaboration: Redux

Thus far I have presented the argument that current professional practices combined with bureaucratic organizational structures do not support efforts to achieve the client-centered, collaborative service delivery presumably desired by schools and human service agencies. The literature on interagency collaboration

demonstrates that it is difficult to accomplish, no one best method exists for achieving successful collaboration, new knowledge gained from researching collaborative efforts is needed, and the meaning of collaboration is contentious (Noblit & Richards, 1993). What is more crucial is what the interagency collaboration literature omits. The numerous guidelines, prescriptions, and formulas for achieving the ideal of interagency collaboration fail to consider the preferences or desires of the clients in the design of the service system.

As an example, a study conducted by the North Carolina State Department of Public Instruction on the current state of interagency collaboration, found that clients would receive the services normally provided by agencies, rather than the services s/he actually needed. With or without collaboration, there was no systematic effort to determine what clients actually needed to resolve their concerns. Also, the school system rarely participated in collaboration, and more often than not, the teachers were unaware that their students were involved with other human service agencies (Noblit & Richards, 1993).

Furthermore, if, as it has been proposed (Perrow, 1978; Ferguson, 1984), that a main function of human service organizations is to serve as resources for other service agencies, it belies interagency collaboration as a method for maximizing effective service delivery. If agencies need one another primarily for survival, who actually benefits from collaboration? It has also been suggested that social problems are the exclusive domain of schools, agencies and human service professionals, as they alone have the expertise for proposing remedies. Typical proposed solutions to social problems are to create new programs and hire more professionals, thus perpetuating dependence on human service agencies and advancing professional agendas(Street, 1978).

Also, one might ask, with whom are agencies collaborating? The phrase "interagency collaboration" implies collaboration between professionals of different

schools/agencies rather than with those seeking services. Additionally, given the current state of professional practice and the bureaucratic structure of schools and service agencies, what are the possibilities for achieving genuine, child/family/client-centered, collaborative practice? Current organizational structures and professional practices do not support client-centered practice, much less collaborative efforts among professionals and schools/agencies. New structures and professional practices based on alternative values and assumptions are needed to reorient the service delivery system toward genuine collaborative, client-centered practice.

Possibilities for Reframing

A transformation of the human service system will require extensive revisions of public policy, flexible funding options, and considerable restructuring of university preparation programs. Additionally, we must begin to rethink and redefine traditional conceptions of what it means to engage in child/family/client-centered, collaborative practice. We must reject prevailing notions that child/family/client-centered practice means acquiescing to professional expertise. We must reject conceptions of interagency collaboration that preclude and exclude partnerships with the families and individuals in need of services.

In their book, *Habits of the Heart*, Bellah, et al (1985) discussed the loss of community we have experienced as the result of pursuit of personal goals, accumulation of material wealth, and rampant consumerism, often at the expense of others. They reminded us,

> ...we might begin to make moral sense of the fact that there are cultural differences among us, that we do not all want the same thing, and that it is not a moral defect to find other things in life of interest besides consuming ambition. In short, a restored social ecology might allow us to mitigate the harm that has been done to disadvantaged people without blaming the victims or trying to turn them into carbon copies of middle-class high achievers (p. 289).

They also spoke of "reappropriating tradition" (p. 292), or finding sustenance in tradition and applying it actively and creatively to our present realities. History informs us that communities and families provided support to one another rather than relying on government agencies and insititutions. Perhaps by reappropriating the tradition of community as a source of support and strength, coupled with needed professional services, we can begin restoring our fractured social ecology.

How different might the lives of Jeremy, Amy and Michael be if schools and service agencies genuinely worked in concert with them and their families? Community-based programming would be redefined to mean bringing services to the community, with emphasis placed on strengthening and thus preserving families in order to prevent removal of children from their homes. Children who do require out-of-home placements (due, for example, to the incarceration or hospitalization of the primary caregiver) would be placed with other members of the community in an effort to minimize the trauma and disruption of their lives.

Since each community and each family has different needs, a flexible array of services designed to meet their diverse needs would be available. Instead of prescribing for and operating on "clients," human service professionals would function as enablers, advocates, teachers, and partners. An alternative approach to service delivery emphasizes strengths and competencies rather than deviance, pathology, and victimization.

Additionally, rather than agencies operating as separate, often parallel entities, services would co-exist at a single site, organized non-hierarchically under a single administrative umbrella, perhaps at the school or other central location. Services would be available in the homes of families if that is their desire. Leadership and administrative responsibilities based on democratic values would be shared, with the ultimate goal of teaching members of the community to assume leadership roles. Ideally, for students with disabilities, needed special education services would be

available in regular classrooms and segregated special education programs would cease to exist.

By redefining the meanings of "client-centered practice" and "collaboration," those who otherwise would be constructed as human service clients can be empowered by their active involvement with identifying and solving their own problems, rather than simply passively receiving services prescribed for them by others. In this sense, collaboration as equal partners occurs not only between professional service providers, but in concert with those seeking services.

Commitment to the ethic of caring is central to this redefinition. As conceived by Noddings (1984), caring is relational and receptive, certainly desirable values for administrators, teachers and human service workers. Teaching and human service work are caring professions, yet caring is often not valued in schools and human service organizations. In her alternative vision of schools as centers of care, Noddings (1992) discussed the importance of planning for continuity of purpose, place, people, and curriculum. These aspects of continuity are also applicable to services children and their families might need that the school alone is unable to provide.

It should be clear that schools and human service programs are centers of care and that their central purpose is caring. Offering services locally at a single site or in the home achieves continuity of place. For many, transportation is a barrier to accessing services, and by providing services on-site or in their homes, those in need will no longer be required to visit numerous agencies scattered throughout the town or county. By assigning professionals to each community-based program, they can develop connections and relationships with the entire community, not just with isolated individuals from various locales. Members of the community would also participate in the process of hiring the professionals to work in their programs. Administrators, human service professionals, teachers, and families would become

strong allies and advocates to ensure that continuity of the child's program occurs once s/he leaves the classroom.

To this end, borrowing from the work of feminist writers Fine & Gordon (1992), the following understandings must be considered when discussing transformation of human service organizations and professional practice: (1) Power asymmetries structure the professional-client/student relationship; (2) Client status intersects with disability, gender, social class, race/ethnicity, sexual orientation, and social context to produce socially and historically constituted subjectivities; (3) In collaboration with families/individuals with needs, the meanings of social experience as expressed by them must be revealed; and (4) Contextualized research in collaboration with administrators, teachers, service providers and service receivers is needed to produce viable alternative structures and practices that will enable individuals to enhance their relationships with families and significant others in order to sustain connections with a caring community service system.

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